MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01919

1916 **CERTIFICATE OF DEATH** Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air, Md.
c. LENGTH OF STAY IN 1b: 3YRS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: HARFORD COUNTY HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FOREST HILL
d. STREET ADDRESS: BEL AIR, Md.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle J. — Last BARRETT

4. DATE OF DEATH: Month FEB. — Day 26 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 23, 1882

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRACTTIAL MALE NURSE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ~~MARYLAND~~ Wisconsin

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: RICHARD BARRETT

14. MOTHER'S MAIDEN NAME: MARY CONLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 221-10-9419 ~~NONE~~

17. INFORMANT — Address: Mrs. Helen B. Mattingly P.O. 126, Leonardtown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Chr. Hypertensive Cardio-vascular disease — 10 yrs?
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1955, to Feb. 26, 1959, that I last saw the deceased alive on Feb. 24, 1959, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: Feb. 26, 1959

PHYSICIAN'S NAME (Type): WILLARD P. HUDSON M.D. — FOREST HILL, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/28/59
22c. NAME OF CEMETERY OR CREMATORY: Our Lady's
22d. LOCATION (City, town, or county) (State): Medley's Neck, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. Clarke Mattingley Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01920

1917 **CERTIFICATE OF DEATH**

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air

LENGTH OF STAY (in this place) 35 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Feb 11/59 COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Md

STREET ADDRESS (If rural give location) Bond St

3. NAME OF DECEASED (Type or Print) (First) Walter (Middle) E (Last) Bennington

4. DATE OF DEATH (Month) Feby (Day) 11 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	White	Married	Nov 11 - 1898	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Policeman	Whiteford Harford Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Bennington	Florence Targert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
yes	WORLD I	215-22-8065	Mrs Florence E Bennington Bel Air Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X IMMEDIATE CAUSE (A) CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

ANTECEDENT CAUSE(S) DUE TO (B) HYPERTENSIVE CARDIOVASCULAR DISEASE — 10 YRS

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAR, 19 47, to FEB, 19 59, that I last saw the deceased alive on 9 FEB, 19 59, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

SIGNATURE AND M.D. J. P. Sedwell — ADDRESS (Street, city, town, state) 40 Hamilton St Bel Air Md — DATE SIGNED 11 Feb 59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feby 13/59	Bel Air Memorial Gardens	Bel Air Harford Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE FEB 13 '59	Arthur L. Kraus	Joseph T Foster	Bel Air Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1931 — 01921 — Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL" and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RD 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jordz
d. STREET ADDRESS: RD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ray — Middle: VanLear — Last: Bowser JR
4. DATE OF DEATH: Month: February — Day: 28 — Year: 1959

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 4, 1938
9. AGE (In years last birthday): 20 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter Helper
10b. KIND OF BUSINESS OR INDUSTRY: Shipyard
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Ray VanLear Bowser SR
14. MOTHER'S MAIDEN NAME: Marie Mulligan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-34-5906
17. INFORMANT: Roy VanLear Bowser — Address: Box 219 RD 1 Stockton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH
816 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto-auto accident
20c. TIME OF INJURY: Hour: 1130 p. m. — Month, Day, Year: 2-28 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RD 2
20f. (City or town) (County) (State): Bel Air Harford Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Baltimore Md — DATE SIGNED: 3-1-59
EXAMINER'S NAME (Type): Gerald E Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: MAR 4 1959
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Joseph J. Foster, Bel Air, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Evans

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1918 **CERTIFICATE OF DEATH** Reg. Dist. No. 01922

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 23 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Edgewood
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Howard Middle Woodrow Last Bull
4. DATE OF DEATH Month February Day 25 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 8, 1913
9. AGE (In years last birthday) 45 yrs.
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Milton J. Bull Sr.
14. MOTHER'S MAIDEN NAME Annie Elliott
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 212-10-8887
17. INFORMANT Mr. Sewell Bull Address 44 East Gordon St. Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 24 hr.
331 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-24-, 19 59, to February 25 19 59, that I last saw the deceased alive on February 24, 19 59, and that death occurred at 9:32 A. M., from the causes and on the date stated above.
ACTUAL SIGNATURE M.D. ADDRESS (Street, city or town, state) 6 Low St. DATE SIGNED 2-26-59
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D. Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 27, 1959
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State) Bel Air, Harford Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Tretter ADDRESS W. Broadway & Hill Sts. Bel Air, Maryland
24a. REC'D BY REGISTRAR DATE MAR 2 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kerr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1919

CERTIFICATE OF DEATH

01923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: New Jersey b. COUNTY: Gloucester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clayton. 67x-3
d. STREET ADDRESS: 339 N. Pearl St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: SUSANNA Middle: Last: CAMPBELL

4. DATE OF DEATH Month: Febuary Day: 25 Year: 1959

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1870

9. AGE (In years last birthday): 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Duties

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Phila. Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George W. Coward

14. MOTHER'S MAIDEN NAME: Emily Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: Mildred Hills - Abingdon Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding from upper G. I. Tract

578x

DUE TO (b) (Not determined)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 1 wk

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1959, to 2-25, 1959, that I last saw the deceased alive on 2-25, 1959, and that death occurred at 10:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman M.D.

ADDRESS (Street, city or town, state): 8 E. Law St. - Aberdeen, Md.

DATE SIGNED: 2-26-59

PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried

22b. DATE THEREOF: Feb 28/59

22c. NAME OF CEMETERY OR CREMATORY: Chickory Chapel

22d. LOCATION (City, town, or county) (State): Monroeville N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington ADDRESS: Havre de Grace Md

24a. REC'D BY REGISTRAR DATE MAR 2 '59

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1952 — 01925

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 2 years 6 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RD 2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS: 12 Williams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: Jeff — Last: Chadwick

4. DATE OF DEATH: Month: February — Day: 28 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 27 - 1941

9. AGE (In years last Birthday): 17 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School
10b. KIND OF BUSINESS OR INDUSTRY: Student

11. BIRTHPLACE (State or foreign country): Washington D C

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George A Chadwick

14. MOTHER'S MAIDEN NAME: Dorothy R Rickord

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Dorothy R Chadwick, 12 Williams St Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Compound fracture skull — INTERVAL BETWEEN ONSET AND DEATH

816x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Fracture both femora

DUE TO (c): Crushing injury chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident - Auto - auto type

20c. TIME OF INJURY: Hour: 11:58 a.m. p.m. — Month, Day, Year: 2-28 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RD 2

20f. (City or town) (County) (State): Bel Air Harford Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Bel Air Md

DATE SIGNED: 3-1-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE: Mar 3/59

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph J Foster

ADDRESS: Bel Air, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. (Reg. 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.)

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1920

CERTIFICATE OF DEATH

Reg. Dist. No. 01925

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 47 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS Paradise Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Hollis Last Coale
4. DATE OF DEATH Month 2 Day 4 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 8th. 1888
9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Hannah Smith.
14. MOTHER'S MAIDEN NAME Mary Hendon.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Clyde Foote Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid — INTERVAL BETWEEN ONSET AND DEATH 3 mo.
199.2
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1953, 19__, to 2-4-, 1959, that I last saw the deceased alive on 2-4-, 1959, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Peter P. Rodman, M.D. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED

PHYSICIAN'S NAME (Type) Peter P. Rodman Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/7/59
22c. NAME OF CEMETERY OR CREMATORY Trinity Episcopal Cem.
22d. LOCATION (City, town, or county) (State) Churchville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John G. Farring
ADDRESS Aberdeen, Md
24a. REC'D BY REGISTRAR DATE FEB 10 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01926
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. The funeral director should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — b. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: instant
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RD 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Bel Air
d. STREET ADDRESS: RD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gene Middle Winfield Last Cullum
4. DATE OF DEATH: Month February Day 28 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 14, 1939
9. AGE (In years last birthday): 19 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Inspector
10b. KIND OF BUSINESS OR INDUSTRY: National Guard
11. BIRTHPLACE (State or foreign country): Harford Co., Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.,
13. FATHER'S NAME: Roland R. Cullum
14. MOTHER'S MAIDEN NAME: Elsie Mitchell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-36-9373
17. INFORMANT Address: Roland R. Cullum, Bel Air, R.D., Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH
816 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Compound, comminuted fracture
DUE TO (c): both bones both legs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident, auto - auto type
20c. TIME OF INJURY Hour: 1158 a.m. p.m. Month, Day, Year: 2-28 19 59
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RD 2
20f. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED: 3-1-59
EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 4, 1959
22c. NAME OF CEMETERY OR CREMATORY: Calvary
22d. LOCATION (City, town, or county) (State): Calvary, Harford, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Howard R. McComas Jr — ADDRESS: Abingdon, Md.,
24a. REC'D BY REGISTRAR DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Instant

19

Truck Inspector National Guard Bel Air, Md.

Roland R. Cullum Dale Mitchell

No [illegible] Roland R. Cullum, Bel Air, Md., Maryland

Burial Mar. 1, 1959 Calvary Calvary, Harford, Maryland

Abingdon, Md.,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1921 CERTIFICATE OF DEATH

01927

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL Air

LENGTH OF STAY (in this place) 30

HOSPITAL OR INSTITUTION OR STREET ADDRESS Fulford Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 BEL Air

STREET ADDRESS (If rural give location) Fulford Ave.

3. NAME OF DECEASED (Type or Print) (First) Nicholas (Middle) J. (Last) DEMAS

4. DATE OF DEATH (Month) Feb. (Day) 17, (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	JUNE 5, 1892	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Restaurant Proprietor	Restaurant	Trikkala, Greece	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Demas	Helen Demas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO		214-34-4565	Mrs. Mary Charas Demas 102 Fulford Ave. Bel Air, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE	(A) Myocardial Infarction	1/2 hour
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(B) Coronary thrombosis	several hours
DUE TO	(C) ARTERIOSCLEROTIC and hypertensive cardiovascular disease	10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Intermittent congestive heart failure	5 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 13, 1954, to Feb. 17, 1959, that I last saw the deceased alive on Feb. 17, 1959, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Paul L. Manos Jr. M.D.	115 Fulford Ave., Bel Air, Md.	2/18/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/20/1959	Bel Air Memorial Gardens	Bel Air, Harford Co., Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
FEB 20 '59	C. Thos. L. Hanna	Joseph W. Foster	W. Broadway + Williams St. Bel Air, Maryland

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy on this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1934 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01928

Item 7 FilmG239 3-13-59 et

Reg. Dist. No.

1 FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna. b. COUNTY Phila
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75 x-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hopkins Cove, Susquehanna River
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First V 1999 Middle Hansen Last
4. DATE OF DEATH Month February Day 27 Year 1959

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 19 1889
9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer
10b. KIND OF BUSINESS OR INDUSTRY Phila Electric
11. BIRTHPLACE (State or foreign country) Del
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Hansen
14. MOTHER'S MAIDEN NAME Maria Christenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Wm. J. Hansen Address Kemberg Road Upper Darby Penna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decerebration
863x
DUE TO (b) Third degree burns entire body
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Helicopter hit power wire & crashed
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 2-27-59
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River
20f. (City or town) Conowingo (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air Md DATE SIGNED
EXAMINER'S NAME (Type) Gerald C Palmer
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ 2-27-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Feb. 28, 1959
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY Nashville Tenn
22d. LOCATION (City, town, or county) (State) Burt of Phila Penna

23. FUNERAL DIRECTOR'S SIGNATURE H D Bailey ADDRESS Darlington Md
24a. REC'D BY REGISTRAR DATE MAR 5 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1935 CERTIFICATE OF DEATH

Reg. Dist. No. 01929

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jarrettsville
c. LENGTH OF STAY IN 1b: 1 mon.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Street
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ANNIE Middle MARY Last HASLETT.

4. DATE OF DEATH: Month Feb. Day 17 Year 1959

5. SEX: Female /Male/

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 29, 1884

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Shane, Balto. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Simms

14. MOTHER'S MAIDEN NAME: Mc Clairy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 0-------

17. INFORMANT: Lewie W. Haslett Address: Street, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-vascular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1958, to 17 Feb, 1959, that I last saw the deceased alive on 17 Feb, 1959, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos. A. E. Moxley M.D. — ADDRESS (Street, city or town, state): Jarrettsville, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/19/1959

22c. NAME OF CEMETERY OR CREMATORY: William Watters

22d. LOCATION (City, town, or county) (State): Cooptown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz ADDRESS: Jarrettsville Md.

24a. REC'D BY REGISTRAR DATE: FEB 24 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ... page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1922 CERTIFICATE OF DEATH

01930

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace

LENGTH OF STAY (in this place) 20 Min.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill Rural

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) DORA (Middle) ALBERTA (Last) HORN

4. DATE OF DEATH (Month) February (Day) 2, (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Feb. 9, 1898	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Pa.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Robb	Emma Coler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	-------		Mrs. Harvey Keys Forest Hill Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) Pulmonary Edema, acute — INTERVAL BETWEEN ONSET AND DEATH: 2 or 3 hours

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Congestive Heart failure — 1 year

DUE TO (C) Arteriosclerotic cardiovascular disease — 10 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes mellitus — 2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 19 57, to Feb. 1, 19 59, that I last saw the deceased alive on Feb. 1, 19 59, and that death occurred at 6:50 A.M, from the causes and on the date stated above.

SIGNATURE for Paul S. Stonesifer, Jr. M.D. — ADDRESS (Street, city, town, state) 115 Fulford Ave., Bel Air, Md. — DATE SIGNED 2/2/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, or town, county) (State)
Burial	2/4/1959	Bel Air Memorial Garden	Bel Air Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
FEB 4 '59	Arthur L. Kraus	Charles E. Hurst	Jarrettsville Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1936

Reg. Dist. No. 01931

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION R.D. #1, Box 364

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Aberdeen (Rural)
d. STREET ADDRESS R.D. #1, Box 364
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First FRANKLIN Middle O. Lost JOHNSON
4. DATE OF DEATH Month February Day 18 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH Sept 24, 1916
9. AGE (In years last birthday) 42 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Oscar M. Johnson
14. MOTHER'S MAIDEN NAME Mary Alice Palmer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-07-4878
17. INFORMANT Ruth Greenland, Address 441 W. Bel Air Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma R lung. 162.1
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify thot I attended the deceased from 6-15, 1958, to 2-18, 1959, that I last saw the deceased olive on 2-18, 1959, ond thot deoth occurred at 9 P M, from the causes ond on the date stoted obove.

ACTUAL SIGNATURE Gerald C Palmer M.D. ADDRESS (Street, city or town, stote) Bel Air, Md. DATE SIGNED 2-18-59

PHYSICIAN'S NAME (Type) Gerald C Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2/21/59
22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery
22d. LOCATION (City, town, or county) (State) Perryman, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE John H Tarring ADDRESS Tarring Funeral Home Aberdeen, Md.
24a. RECEIVED BY REGISTRAR DATE FEB 24 '59
24b. REGISTRAR'S SIGNATURE Arthur S Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRE[illegible]: After this certificate has been signed by the attending physician and completely filled in by the [illegible]ral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 sh[illegible] be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01932

1937 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: 16 yrs.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Regina — Last: Johnson

4. DATE OF DEATH: Month: Feb. — Day: 1, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 13, 1900

9. AGE (In years last birthday): 58 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboratory Tech.,

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Harry G. Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-22-0997

17. INFORMANT: Boyd N. Johnson, Address: Edgewood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH
171X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Metastasis Run out Abdomen
DUE TO
(c): Hemorrhage, Indary to Carcinoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/28, 1958, to 2/1, 1959, that I last saw the deceased alive on 2/10, 1959, and that death occurred at 10:35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Louis Kahan M.D. — ADDRESS (Street, city or town, state): Box 966 Edgewood Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): E. Louis Kahan — Edgewood Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 4, 1959

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air, Harford, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L. Watters Jr.

ADDRESS: Abingdon, Maryland.

24a. REC'D BY REGISTRAR DATE FEB 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Female White Mary Jenkson Feb. 1, 1959

Dec. 13, 1900 58

Laboratory Tech., U.S. Govt., Baltimore, Maryland U.S.A.,

Mary C. Smith Unknown

no 218-22-0297 Boyd N. Johnson, Edgewood, Maryland

S. Doris Kahan Ky Edgewood Maryland

Burial Feb.4, 1959 Bel Air Memorial Gardens Bel Air, Harford, Maryland.

Abingdon, Maryland.

16 yrs.,

Edgewood

Maryland

Harford

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1938

CERTIFICATE OF DEATH

01933

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 17 Min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 16 Chesapeake Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREELAND — Middle — Last JONES

4. DATE OF DEATH: Month February — Day 14 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 Feb 59

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months — Days; IF UNDER 24 HRS. Hours — Min. 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carroll Freeland Jones

14. MOTHER'S MAIDEN NAME: Gloria Hannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Father — Address 16 Chesapeake Ct Aberdeen Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity (Previable Infant) — INTERVAL BETWEEN ONSET AND DEATH: 17 min
776 x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1:03PM 14 Feb 19 59 to 1:20PM 14 Feb 19 59, that I last saw the deceased alive on 1:20PM 14 Feb 19 59, and that death occurred at 1:20P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles H P Westfall M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 14 Feb59

PHYSICIAN'S NAME (Type): CHARLES H P WESTFALL MAJOR MC — US ARMY HOSPITAL Aberdeen PG Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-18-59
22c. NAME OF CEMETERY OR CREMATORY: Post Cemetery
22d. LOCATION (City, town, or county) (State): A. P. G. Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Otelia J. Bullock - Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: FEB 20 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

205021XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01934

CERTIFICATE OF DEATH

1939

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route #1, Box 72

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Aberdeen,
d. STREET ADDRESS: Route #1, Box 72
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES — Middle ALONZO — Last KEITHLEY
4. DATE OF DEATH: Month February — Day 1 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 20 Sept. 1877
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: James Keithley
14. MOTHER'S MAIDEN NAME: Cathrine Cullum
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-14-2358
17. INFORMANT: Mrs. CHas. Alonzo Keithley, Aberdeen, Md. — Address R.D. 1, B.72

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive heart failure	2 wk
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic heart disease	6 yr.
DUE TO (c)		

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-29-59, 19__, to 2-1-59, 19__, that I last saw the deceased alive on 1-29-59, and that death occurred at 7:30PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D. — ADDRESS (Street, city or town, state): 8 Law Street — DATE SIGNED

PHYSICIAN'S NAME (Type): Peter P. Rodman — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/4/1959
22c. NAME OF CEMETERY OR CREMATORY: St. Paul Luthern
22d. LOCATION (City, town, or county) (State): R.D. Aberdeen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.
24a. REC'D BY REGISTRAR DATE: FEB 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

ITEMS 13 & 17- FILM G240-37 19739-MHC

1940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 FilmG239 3-9-59 et

01935 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pennsylvania b. COUNTY Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villanova 75x-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Hopkins Cove, Susquehanna River
d. STREET ADDRESS 609 Spruce Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Gerhart Middle Last Klapper
4. DATE OF DEATH Month February Day 27 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 1, 1913
9. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Phila Electric Co
11. BIRTHPLACE (State or foreign country) Pa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Walter KLAPPER Klapper
14. MOTHER'S MAIDEN NAME Dora Radtke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Many War II
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs Patricia Klapper (KLAPPER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decerebration
863X
DUE TO (b) Fracture both femora
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Helicopter hit power line
20c. TIME OF INJURY Hour 6 a.m. p.m. Month, Day, Year 2-27 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River
20f. (City or town) Conowingo (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald e Palmer M.D. CHIEF MEDICAL EXAMINER ☐ Bel Air, Md. DATE SIGNED
EXAMINER'S NAME (Type) Gerald e Palmer M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ 2-27-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 28, 1959
22c. NAME OF CEMETERY OR CREMATORY West Laurel Hill
22d. LOCATION (City, town, or county) (State) Phila, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE C. Wallace Stuard Jr. ADDRESS Ardmore, Pa.
24a. REC'D BY REGISTRAR DATE MAR 5 '59
24b. REGISTRAR'S SIGNATURE Catherine S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1941

CERTIFICATE OF DEATH

Reg. Dist. No. 01936

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Ralph Middle: O. Last: Knight

4. DATE OF DEATH Month: Feb. Day: 17 Year: 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 4 1896

9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Woolmaker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Harford Co Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Wilson Knight

14. MOTHER'S MAIDEN NAME Bessie Low

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Robert Knight Address Harve de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Heart Attack — INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO
(b) Cardiac Asthma — 1 Yr.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 1959 to Feb 17, 1959, that I last saw the deceased alive on Feb 15, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE L P Snodgrass M.D. ADDRESS (Street, city or town, state) Darlington Md DATE SIGNED 2/18/59

PHYSICIAN'S NAME (Type) L P Snodgrass

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) — 22b. DATE THEREOF Feb 19, 1959 — 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem — 22d. LOCATION (City, town, or county) Baltimore (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE H D Bailey — ADDRESS Darlington Md

24a. REC'D BY REGISTRAR DATE FEB 24 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1923 CERTIFICATE OF DEATH

01937
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Conv. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air
d. STREET ADDRESS: Rt. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: N. — Last: McCrobie

4. DATE OF DEATH: Month: February — Day: 8 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 7, 1880
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Johnson Duncan
14. MOTHER'S MAIDEN NAME: Ruth Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mrs. Lillian Trusler, Rt. # 3, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
420.1
DUE TO (b): Chr Cardio-vascular disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): With Hypertension — 12 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hemiplegia (Rt-Sided) Due To Cerebral Vasc. Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1950, 19____, to Feb. 8, 19 59, that I last saw the deceased alive on Feb. 7, 19 59, and that death occurred at 1:30 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D — ADDRESS (Street, city or town, state): Forest Hill Md — DATE SIGNED: 2/9/59
PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/11/59
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph T. Foster — ADDRESS: Bel Air Md
24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01938

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hopkins Cove, Conowingo
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hopkins Cove, Susquehana River

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New York — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 69x-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Henry — Last: Meier

4. DATE OF DEATH: Month: February — Day: 27 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ ~~NEVER MARRIED~~ ☐ WIDOWED ☐ ~~DIVORCED~~ ☐

8. DATE OF BIRTH: June 12, 1922

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pilot - Helicopter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York City

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wm H Meier

14. MOTHER'S MAIDEN NAME: Margaret Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No War 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Giles Meier — Address: 103 Mapazan New York City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing Injury of chest with rupture of heart.
863x
DUE TO (b): Compound, comminuted fracture of skull
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Third Degree Burns.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Helicopter hit power line

20c. TIME OF INJURY: Hour: 6 p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Suspuehana River

20f. (City or town): Conowingo — (County): Harford — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt Jr. M.D.
EXAMINER'S NAME (Type): William V. Lovitt Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Bel Air, Md.
DATE SIGNED: 2/28/59

22a. BURIAL, CREMATION, REMOVAL (Specify):
22b. DATE THEREOF: Feb. 28, 1959
22c. NAME OF CEMETERY OR CREMATORY: New York City Mem
22d. LOCATION (City, town, or county): New York City — (State):

23. FUNERAL DIRECTOR'S SIGNATURE: H D Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR DATE: MAR 3 '59

24b. REGISTRAR'S SIGNATURE: Dorothea S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1943

CERTIFICATE OF DEATH

Reg. Dist. No. 01939

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks
c. LENGTH OF STAY IN 1b: 8 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES Middle P. Last MILLER.

4. DATE OF DEATH: Month FEB Day 1 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 12, 1913
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rocks, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Condon Lay Miller
14. MOTHER'S MAIDEN NAME: Elsie Groof

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs W. D. Pinkard - First National Bank Bldg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb, 1957, to Feb 1, 1959, that I last saw the deceased alive on 20 Jan, 1959, and that death occurred at 1 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos. A.E. Mosley Jr. M.D. — ADDRESS (Street, city or town, state): Darlington, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Thos. A.E. MOSELEY, JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: St James Cemetery
22d. LOCATION (City, town, or county) (State): My Lady's Manor. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Jenkins & Sons Co. ADDRESS: 4905 YORK, Rd.
24a. REC'D BY REGISTRAR DATE: FEB 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1944 **CERTIFICATE OF DEATH**

D1940

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BEL AIR

LENGTH OF STAY (in this place) 7 Mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD CONVALESCENT HOME

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD. COUNTY HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PYLESVILLE

STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED (Type or Print) (First) Bessie (Middle) F. (Last) Neal

4. DATE OF DEATH (Month) 2- (Day) -9- (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W.		Oct. 25, 1884	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE	Own Home	YORK Co., PENNA	U.S.A.

13. FATHER'S NAME TOM WRIGHT

14. MOTHER'S MAIDEN NAME LAURA TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS Samuel J. Neal Pylesville, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSE(S) DUE TO (B) Chr. Cardio-vascular disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 4, 1958, to Feb. 9, 1959, that I last saw the deceased alive on Feb. 8, 1959, and that death occurred at 12 P.M., from the causes and on the date stated above.

SIGNATURE Willard P. Hudson M.D. ADDRESS (Street, city, town, state) Forest Hill, Md. DATE SIGNED 2-9-59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-12-59	SALEM METH. CEM.	DELTA, YORK Co., PA.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE FEB 16 '59	Arthur L. Krause	Kenneth W. Anderson	Stewartstown, Pa.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1924

CERTIFICATE OF DEATH

01941 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE de GRACE
c. LENGTH OF STAY IN 1b 45 hrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Street
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Lost NEWCOMB
4. DATE OF DEATH Month FEBRUARY Day 21 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH SEPT. 2, 1890
9. AGE (In years last birthday) 68 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) BALTO., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Cooper
14. MOTHER'S MAIDEN NAME MARY DENNIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address MRS. WM. PATRICK, DARLINGTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Block — Chronic Myocarditis
DUE TO (b) Cardio-Vascular Renal Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
442 X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/17, 19 59 to 2-28 19 59 that I last saw the deceased alive on 2/20, 19 59, and that death occurred at 7:50 A.M, from the causes and on the date stated above.
ACTUAL SIGNATURE [signature] M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED 2/28/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 2-23-59
22c. NAME OF CEMETERY OR CREMATORY Holy Cross
22d. LOCATION (City, town, or county) (State) STREET, HARFORD Co. MD.

23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Pa.
24a. REC'D BY REGISTRAR DATE FEB 26 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01942

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Patricia — Middle: S. — Last: Percy

4. DATE OF DEATH: Month: February — Day: 9 — Year: 1959

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 12-10-38 — 9. AGE (In years last birthday): 20 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis S. Silver
14. MOTHER'S MAIDEN NAME: Sarah Ellicott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sara E Silver — Address: Darlington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral contusion — INTERVAL BETWEEN ONSET AND DEATH: -

DUE TO (b): L. Pneumothorax — -

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

816 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident, auto-auto type
20c. TIME OF INJURY: Hour: o. m. / p. m. 2-5 — Month, Day, Year: 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Deer Creek Bridge
20f. (City or Town): Rt. 1 Street — (County): Harford — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air, Md — DATE SIGNED: 2-10-59

EXAMINER'S NAME (Type): Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Feb. 11, 1958
22b. DATE THEREOF:
22c. NAME OF CEMETERY OR CREMATORY: Darlington Cem.
22d. LOCATION (City, town, or county): Harford Co. — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H S Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR DATE: FEB 16 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1945 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01943
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
c. LENGTH OF STAY IN 1b: 30 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RURAL RD#2 Box 52 ~~Shucks Rd~~ Schucks Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BEL AIR (RURAL)
d. STREET ADDRESS: RD#2 Box 52 ~~Shucks Rd~~ Schucks Rd
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LUTHER — Middle ESTEL — Last QUILLEN

4. DATE OF DEATH: Month FEBRUARY — Day 21 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: NOV. 20, 1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARION QUILLEN

14. MOTHER'S MAIDEN NAME: ELISABETH WALTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-24-1301

17. INFORMANT: (WIFE) EULA
Address: Schucks Road SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 30 MIN

422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: ? OVER 3 YRS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Philip W. Heuman M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: February 21, 1959

EXAMINER'S NAME (Type): PHILIP W. HEUMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feby 24/59
22c. NAME OF CEMETERY OR CREMATORY: Mt Zion
22d. LOCATION (City, town, or county) (State): Fountain Green Harford Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph T Foster
ADDRESS: Bel Air Md

24a. REC'D BY REGISTRAR
DATE: FEB 26 '59

24b. REGISTRAR'S SIGNATURE: Curtis L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1946 CERTIFICATE OF DEATH

Reg. Dist. No. 01943

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
c. LENGTH OF STAY IN 1b: [illegible] DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US ARMY HOSPITAL, APG, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 ABERDEEN
d. STREET ADDRESS: 1 103-G RODMAN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLEM — Middle (none) — Last REID

4. DATE OF DEATH: Month FEBRUARY — Day 28 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 23, 1869

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Reid

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: James E. Pittman, 103G Rodman Road, Aberdeen, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 7 Days
331 X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b): GENERALIZED ARTERIOSCLEROSIS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ o. m. p. m. — Month, Day, Year 19___

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 21, 1959, to February 28, 1959, that I last saw the deceased alive on February 27, 1959, and that death occurred at 3:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J Fraher M.D. — ADDRESS (Street, city or town, state): US Army Hospital — DATE SIGNED: Febraury 28, 59

PHYSICIAN'S NAME (Type): THOMAS J. FRAHER, Captain, MC — Aberdeen Proving Ground, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 3/2/59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Baptist
22d. LOCATION (City, town, or county) (State): Jacksonville, Ala Found

23. FUNERAL DIRECTOR'S SIGNATURE: Elmer E. Bullock — ADDRESS: Havre de Grace, Md

24a. REC'D BY REGISTRAR — DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krumb

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1947 CERTIFICATE OF DEATH

01945 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whiteford
c. LENGTH OF STAY IN 1b: 73 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Whiteford
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle WHITEFORD Last SILVER

4. DATE OF DEATH: Month February Day 17 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 20, 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Flintville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Whiteford

14. MOTHER'S MAIDEN NAME: Mary E. Gladden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: David Silver, Whiteford, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12/26/58
443X
DUE TO (b): Hypertension C-V Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1940, to Feb 17, 1959, that I last saw the deceased alive on Feb 16, 1959, and that death occurred at 2:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Josiah A Hunt M.D. ADDRESS (Street, city or town, state): Delta Pa. DATE SIGNED: 2/19/59

PHYSICIAN'S NAME (Type): Hosiah A. Hunt M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 20, 1959
22c. NAME OF CEMETERY OR CREMATORY: Slateville
22d. LOCATION (City, town, or county) (State): Delta, York Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbaugh
ADDRESS: Delta, Pa.
24a. REC'D BY REGISTRAR DATE: FEB 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1926

CERTIFICATE OF DEATH

01946

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 3 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre-de-Grace
d. STREET ADDRESS 417 Lewis ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Simons

4. DATE OF DEATH Month 2 Day 26 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2/23/59
9. AGE (In years last birthday) — yrs. IF UNDER 1 YEAR Months — Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jay S. Simons
14. MOTHER'S MAIDEN NAME Nancy Easter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Jay S. Simons 417 Lewis St. City.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X
DUE TO (b) Premature (wt 2 lbs) (5-6 months gestation)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/23, 1959, to 2/26, 1959, that I last saw the deceased alive on 2/26, 1959, and that death occurred at 10:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Frank Wolbert MD M.D. ADDRESS (Street, city or town, state) Havre de Grace Md DATE SIGNED 2/27/59

PHYSICIAN'S NAME (Type) FRANK WOLBERT MD

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 2-28-1959
22c. NAME OF CEMETERY OR CREMATORY FARM HARFORD COUNTY ALMS HOUSE
22d. LOCATION (City, town, or county) HARFORD Co. (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS HAVRE DE GRACE, MD
24a. REC'D BY REGISTRAR DATE MAR 2 '59
24b. REGISTRAR'S SIGNATURE Cathryn L. Krauss

2000385XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01947

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 700 S Washington St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: 700 S. Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Aeney Middle Dougan Last Skipper

4. DATE OF DEATH: Month February Day 3 Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Dec. 31, 1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alexander Dugan

14. MOTHER'S MAIDEN NAME: Sarah Cross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ___ (If yes, give war or dates of service) ___

16. SOCIAL SECURITY NO.

17. INFORMANT: Albert Dugan SKIPPER Address: HAVRE DE GRACE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ o. m. p. m. Month, Day, Year 19___

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. — Bel Air, Md. — DATE SIGNED: 2-3-59

EXAMINER'S NAME (Type): Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Feb. 5, 1959

22c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM

22d. LOCATION (City, town, or county) (State): HAVRE DE GRACE MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell ADDRESS: Havre de Grace MD.

24a. REC'D BY REGISTRAR DATE: FEB 5 '59

24b. REGISTRAR'S SIGNATURE: Carling E. Kirwan

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1927 — 01948 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ryans Trailer Camp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 131 N. Phila. Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Donald — Middle: Eugene S — Last: Tyer
4. DATE OF DEATH: Month: February — Day: 8 — Year: 1959

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 8, 1958
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 2 — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Charles L. Styer
14. MOTHER'S MAIDEN NAME: Florence Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Father — Address: 131 N. Phila Blvd Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: —
491 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remoins described obave, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my apinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air Md — DATE SIGNED: 2-10-59
EXAMINER'S NAME (Type): Gerald E Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/59
22c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Barney — ADDRESS: Aberdeen Maryland
REC'D BY REGISTRAR DATE: FEB 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

20 7/24 4 x V 5

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within [redacted] hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1949 CERTIFICATE OF DEATH

01949

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air Rural

LENGTH OF STAY (in this place) 3 Mons.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Convalescing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Jarrettsville

STREET ADDRESS (If rural give location) /

3. NAME OF DECEASED (Type or Print) (First) BESSIE (Middle) MAY (Last) TRACEY

4. DATE OF DEATH (Month) February (Day) 1, (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed	July 16, 1887	71 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Practical Nurse	Nursing	Rocks Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Ervin	Martha Crew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	-------	215-34-5638A	Mrs Helen Crouse RD 1 Aberdeen Md.

18. MEDICAL CERTIFICATION

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE	(A)	Bronchopneumonia, terminal	2 days
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B)	Cerebral thromosis, acutey severe	1 week
	DUE TO (C)	arteriosclerotic cardiovascular disease	10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		carcinoma of cervix (treated 4 months ago; arrested)	1 year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 5, 1959, to Feb. 1, 1959, that I last saw the deceased alive on Feb. 1, 1959, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Paul S. Stonesifer, Jr. M.D.	115 Fulford Ave., Bel Air, Md.	2/2/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/5/1959	North Bend	Rocks RD Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
FEB 4 '59	Arthur L. Kruck	Charles C. Hurtz	Jarrettsville Md

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1950 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01950

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hopkins Cove, Susquehanna River

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Robert Middle E. Last Turner

4. DATE OF DEATH Month February Day 27 Year 19 59

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Mar. 13, 1901

9. AGE (In years last birthday) 57 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLANT ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY Hydro-Electric

11. BIRTHPLACE (State or foreign country) Odebolt, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Turner

14. MOTHER'S MAIDEN NAME Martha Henderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 174-10-7233

17. INFORMANT Address Rebecca Turner, Conowingo, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH

863X

DUE TO (b) Fracture L femur

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Third Degree Burns Body

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Helicopter hit power line

20c. TIME OF INJURY Hour 6 a.m. p.m. Month, Day, Year 2-27 19 59

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Susquehanna River — 20f. (City or town) Conowingo (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — Bel Air Md — DATE SIGNED 2-27-59

EXAMINER'S NAME (Type) Gerald C Palmer M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF Mar. 3, 1959

22c. NAME OF CEMETERY OR CREMATORY Darlington

22d. LOCATION (City, town, or county) (State) Darlington, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Harkins, Delta, Pa.

24a. REC'D BY REGISTRAR DATE MAR 3 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be retained for x

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1928 **CERTIFICATE OF DEATH**

01951

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 2 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 319 Graceford Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 319 Graceford Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEO Middle FRANCIS Last VANCE

4. DATE OF DEATH: Month February Day 6 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1918

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Army Officer

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Francis Vance

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WWII, Korean

16. SOCIAL SECURITY NO.: 214-07-4060

17. INFORMANT Address: Official Military Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Severe Coronary Arteriosclerosis and fatty
420.1
DUE TO: liver.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 6, 1959 to Feb 6, 1959, that I last saw the deceased alive on Feb 6, 1959, and that death occurred at Approx. 3:15p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: X Jerome B. Bryant Jr. MC M.D.
ADDRESS (Street, city or town, state): US Army Hospital Aberdeen Proving Ground, Md
DATE SIGNED: Feb 6, 1959
PHYSICIAN'S NAME (Type): JEROME B. BRYANT Jr., Major, MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-10-59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Cook - Blight Inc. 6009 Harford Rd. Balto. 14, Md.

24a. REC'D BY REGISTRAR DATE: FEB 13 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1929 01952

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b 25 HRS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Baby Middle: Boy Last: WALLS

4. DATE OF DEATH Month: FEBRUARY Day: 2 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-1-59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 24 Min. 54

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: MARION WALLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATELECTASIS
762.5
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) PREMATURITY
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 12 HRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1, 1959, to 2/2, 1959, that I last saw the deceased alive on 2/2, 1959, and that death occurred at 6:20 M, from the causes and on the date stated above.

ACTUAL SIGNATURE J. P. Ross M.D. ADDRESS (Street, city or town, state) 200 A N Union Ave. Havre de Grace, Md. DATE SIGNED

PHYSICIAN'S NAME (Type) J. P. Ross

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 2-2-59

22c. NAME OF CEMETERY OR CREMATORY HARFORD MEMORIAL HOSPITAL

22d. LOCATION (City, town, or county) (State) Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE Hospital Administrator ADDRESS

24a. REC'D BY REGISTRAR DATE FEB 6 '59

24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

2071203XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1930 CERTIFICATE OF DEATH

Reg. Dist. No. 01953

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Ohio b. COUNTY Cuyahoga
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleveland - 6 72 X - 3
d. STREET ADDRESS 2128 East 100th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First HATTIE Middle MILDRED Last WILLIAMS

4. DATE OF DEATH Month February Day 20 Year 1959

5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 28, 1912
9. AGE (In years last birthday) 46 yrs.
IF UNDER 1 YEAR Months 5 Days 8
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Cincinnati, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Childs
14. MOTHER'S MAIDEN NAME Hattie Kelley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 355-18-6884
17. INFORMANT Mr Joseph Williams Address 2128 E 100th Street Cleveland, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO 5

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO (c) Chronic Rheumatic Heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/15, 1959, to 2/20, 1959, that I last saw the deceased alive on 2/20, 1959, and that death occurred at 4:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE George T. Stansbury, M.D. ADDRESS (Street, city or town, state) 569 Revolution St. Havre de Grace, Md. DATE SIGNED 2/20/59

PHYSICIAN'S NAME (Type) George T. Stansbury

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal
22b. DATE THEREOF 2/21/59
22c. NAME OF CEMETERY OR CREMATORY Highland Park Cemetery
22d. LOCATION (City, town, or county) (State) Cleveland Ohio

23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullock ADDRESS Havre de Grace
24a. REC'D BY REGISTRAR DATE FEB 24 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1951 — Reg. Dist. No. 01954

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): RD 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Churchville
f. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joan — Middle: Dell — Last: Wilson

4. DATE OF DEATH: Month: February — Day: 28 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 14 Sept. 1942

9. AGE (In years last birthday): 16 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Woodrow Wilson

14. MOTHER'S MAIDEN NAME: Ruby Mae Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: T.W. Wilson, Address: Churchville, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Skull
DUE TO (b): Fracture L femur
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

816X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident auto - auto type

20c. TIME OF INJURY: Hour: 1:15 p. m. — Month, Day, Year: 2-28 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RD 2

20f. (City or town): Bel Air (County): Harford (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Bel Air, Md DATE SIGNED: 3-1-59

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 3/3/59

22c. NAME OF CEMETERY OR CREMATORY: Miller Cemetery

22d. LOCATION (City, town, or county) (State): Webster Springs, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Farring
ADDRESS: Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss